Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of:

	)
Notice of Proposed Rulemaking (NPRM)	) WC Docket No. 02-60
Regarding the Universal Service Support Mechanism	)
For Rural Healthcare	)

Comments of the American Telemedicine Association on the Further Notice of Proposed Rulemaking

The American Telemedicine Association (ATA) is pleased to offer our comments on the above-referenced Notice of Proposed Rulemaking. We believe the Federal Communications Commission has a golden opportunity to use its authority within the Universal Service Support Mechanism and work in partnership with other federal agencies, state initiatives, private health payers and other programs to help make health care services available to every American and to fulfill the goals set forth in both the nation's broadband plan and healthcare reform legislation.

ATA is a national non-profit association representing healthcare institutions, health professionals and the corporate world involved in providing healthcare using telecommunications. Founded in 1993, ATA has promoted the deployment of telemedicine as an integral component of modern quality healthcare and have been actively involved in a number of FCC proceedings and telecommunications policy initiatives since its start. The association is governed by a group of world leaders in healthcare and technology. Attachment 1 is a list of our current board of directors.

ATA applauds the Commission and its staff for presenting such a sweeping proposal. We believe the end result of this effort can directly and positively affect the lives of millions of Americans. Consequently, our comments are designed to help the Commission take advantage of this opportunity and make the most efficient and appropriate use of universal service funds.

Summary

ATA proposes that the Commission retarget the proposed Health Infrastructure Program away from construction to encompass certain other infrastructure costs associated with the Rural Healthcare

Support and Health Broadband Services Programs. This avoids duplicating other federal programs and better targets the use of these healthcare funds for healthcare services. We propose that the existing Rural Healthcare Support program continue to target the most rural health facilities that are faced with extreme costs for broadband services in conformance with Section 254(h)(1) of the Telecommunications Act of 1996 but suggest several enhancements to the program dealing with eligibility, grandfathering and the application process. We also propose that the expanded Health Broadband Services Program be available to all healthcare facilities not participating in the rural health care support program and should not be tied to a geographic definition. This is in conformance with the broader authorization of Section 254(h)(2) of the Telecommunications Act.

ATA's comments are organized in four parts:

I. Retarget the Proposed Health Infrastructure Program

II. Improve the Existing Rural Healthcare Support Program

III. Expand the Proposed Health Broadband Services Program (formerly Internet Access Program)

IV. Data Gathering and Performance Measures

I. Retarget the Proposed Health Infrastructure Program

The NPRM states that the proposed Health Infrastructure Program will support up to 85 percent of the construction costs of new regional or statewide broadband networks to serve public and non-profit health care providers in areas of the country where broadband is unavailable or insufficient. The proposed program would be limited to a maximum of $100 million per year. The Commission staff has estimated that 6-8 projects would be funded per year under this program.

ATA strongly supports the goal of the National Broadband Plan to make broadband telecommunications services available to all citizens, regardless of location. We agree with the Administration that such programs are critical to bridge the digital divide, improve access to education and healthcare services, and boost economic development for communities held back by limited or no access to broadband – communities that would otherwise be left behind.

ATA also recognizes that broadband access needs are significant in many parts of the nation. Such services are needed to improve access to healthcare as well as education, public safety and many other basic requirements of a community. Further ATA supports the use of federal funds to help meet such needs.

However, ATA's support for these objectives does not translate into support for use of universal service healthcare funds for a rural broadband construction program. Experience has shown that a community's needs are best met through a common infrastructure. The U.S. Department of Transportation does not fund education-only highways and the U.S. Economic Development Administration does not fund public service-only water and sewer lines. Such infrastructure is a shared commodity.

The use of universal service healthcare funds to support broadband infrastructure construction is ill advised. These universal service funds can be better used to support the ongoing delivery of healthcare services. We recommend that the $100 million of universal service funds allocated to this proposed initiative should be reprogrammed to support several specific adjunct needs within the Rural Healthcare and Health Broadband Services Programs as described below.

Concerns - Concerns with the proposed Health Infrastructure Program as described in the NPRM are many:

- The proposed program duplicates, and possible conflicts with, the efforts of the Broadband USA program. The **$100 million** set aside for the proposed FCC healthcare construction program removes 25% of the total funding that was originally approved by the FCC to support ongoing healthcare services. Yet, at the same time the amount of funds is small and insignificant compared to the Broadband USA program, which is making available **$7.2 billion** to expand access to broadband services in the United States. The Broadband USA program is administered through the Department of Commerce's National Telecommunications and Information Administration and the Department of Agriculture's Rural Utilities Service. Some have pointed out that the Broadband USA program is a limited one-time-only initiative funded under the American Recovery and Reinvestment Act. However, as identified in a recent *Congressional*

Research Service report[1], there are also a number of continuing programs that provide assistance with the development of broadband access for rural areas such as the ongoing USDA Rural Utilities Service programs[2] as well as numerous state-based programs.

- A simple alternative to creating their own, duplicated effort, would be for the Commission to coordinate activities with existing federally-funded broadband infrastructure programs and perhaps urging those programs to place a priority on FCC-identified areas of need and leveraging the Commission's own authority with the use of the High Cost fund. To be fair, ATA points out that the Commission is not alone in this need for collaboration. ATA has been urging other federal agencies to provide basic coordination among federal programs related to telemedicine for many years.[3]

- The administrative and application processes associated with the Health Infrastructure Program as proposed appears to be even more complicated than the troubled Rural Health Care Pilot Program. Even with the ability to receive administrative support funds, the burden of applicants to provide the required paperwork and meet legal obligations under the proposed program appear to be daunting, requiring an enormous amount of time of the applicant's staff.

- The proposed program would require health providers to also be in the business of telecommunications construction. This is not the expertise of healthcare providers and holds the potential of placing them in competition with commercial providers of broadband services. Many ATA members have expressed concern about this prospect.

---

[1] See "Broadband Internet Access and the Digital Divide: Federal Assistance Programs," Congressional Research Service, 7-5700, August 4, 2010, Table I. Selected Federal Assistance Programs Related to Broadband and Telecommunications Development, page 19.

[2] USDA'S Rural Utilities Service provides programs to finance rural America's telecommunications infrastructure. The Broadband Loan program provides loans to fund the costs of constructing, improving and acquiring facilities to provide broadband service to eligible rural communities. The Distance Learning and Telemedicine program brings electronic educational resources to rural schools and improves health care delivery in rural America. The Community Connect Grant program provides financial assistance to eligible applicants that will provide broadband in underserved areas to provide public safety services and foster economic growth.

[3] For the past two years ATA has been making this suggestion to the Federal Communications Commission, the Office of National Coordinator for Health Information Technology and the White House Office of Science Technology and Policy. Such a body would address the many inefficiencies, duplication and cross purposes of existing federal efforts and would be charged with identifying opportunities for synergy, support for uniform approaches and coordination of telemedicine services. Such an effort will greatly increase efficiency and help each of the agencies to better manage and make use of the technology. Products of the inter-agency body should include specific recommendations on ways to eliminate duplication and leverage federal investments and activities by different agencies within local areas. This may include regulatory actions and special incentive grant programs.

- The program, as proposed, encourages the use of federal funds to purposely overbuild broadband networks. A provision allowing reselling of excess capacity to non-healthcare customers, at best, thwarts Congressional intent in ways that are probably not legally allowed by any other federal program. This is tantamount to a federal hospital construction program that allows grantees to purposely overbuild a hospital, allowing the excess capacity to be used as a hotel. Implementing this provision may lead to a small number of applicants using up all of the allocated funds to the detriment of other legitimate uses focused entirely on healthcare.[4]

- The program, as proposed, gives priority to awarding contracts with two private telecommunications organizations. Both organizations are very reputable non-profit corporations that have contributed significantly to the development of broadband connectivity. However, ATA sees fails to see why the Commission has chosen not to encourage healthcare providers from seeking fair and open competition for the best service and the lowest prices among all telecommunications companies.

- The proposed program limits health care as the sole use of broadband connectivity. In fact, broadband connections are needed in rural America for a host of services in addition to healthcare including education, public safety, libraries, entertainment and retail uses.

- The design of the construction program is primarily aimed at connecting the large centers with very large "pipes." Health networks are focused on serving their end points - local clinics and even doctor's offices. Expanding connectivity to 6-8 large hospital centers with large pipes will not help expand access to care and will not help to meet the goals of national health reform.

Alternative Proposal - Having laid out these concerns, ATA also wants to offer a constructive suggestion to retarget the Infrastructure program. ATA proposes that the Infrastructure program provide the vehicle for other "infrastructure" needs of healthcare providers related to their involvement in the Rural Healthcare Support and Healthcare Broadband Services Programs.

Such a retargeted program would cover expenses in two areas:

[4] ATA notes that this practice has also been allowed and in some cases even encouraged in the current pilot program.

1. Related Telecommunications Equipment - After reviewing Section 254 of the Telecommunications Act, ATA finds no reason why a distinction has been made between health care and schools and libraries programs regarding eligible costs. Thirteen years ago a previous Commission made what appears to be a capricious and arbitrary distinction between the two programs and such an inequity can and should be corrected in this NPRM. In the Commission's May 7, 1997 Universal Service Order it stated that: *"We conclude that sections 254(c)(3) and 254(h)(1)(B) authorize us to permit eligible schools and libraries to receive telecommunications services, Internet access, and internal connections at discounted rates from telecommunications carriers."*[5] However, similar costs for internal connections such as internal wiring are specifically not allowed for healthcare. We believe the original Order was incorrect in not making a similar provision for rural health providers and the programs should be made equivalent.[6] Indeed, the expenses associated with internal connections can prove to be just as a significant barrier as gaining a broadband connection.

   However, ATA is aware of the controversy that has surrounded certain uses of the school and library funds. Therefore, we propose that the Health Infrastructure Program pay only for the costs of switches and routers and other basic equipment for newly participating facilities in the Rural Healthcare Support Program and the Health Broadband Services Program and not be used to duplicate currently available equipment for internal wiring. We also ask the Commission to allow grantees to work together to purchase such equipment through joint, cooperative bidding procedures, allowing for more efficient purchasing arrangements of commonly used items. Together, this appears to be a fair and judicious approach and reflects a growing trend of using wireless routers to provide internal connectivity in lieu of hard wiring.[7]

2. Connecting the rural health site to the local broadband switch - In paragraph 102 of the NPRM, the Commission proposes that a limited amount of funds be available to pay for non-recurring costs - the up-front, one-time-only costs associated with making broadband services available to a

---

[5] FCC 97-157, CC Docket 96-45, *Report and Order*, May 7, 1997 paragraph 29

[6] At minimum, the rural health program (as well as the proposed Health Broadband Services Program) should pay for the costs of all routers and bridges associated with the installation of broadband services to an eligible health provider. For consumers, routers are almost always included in broadband access. Bridges, allowing multiple sites to connect to one another for the purposes of healthcare delivery, are also a fundamental cost of accessing broadband.

[7] ATA offers a rough estimate that providing every qualified facility under the current Rural Healthcare Support Program with this benefit would cost less than $30 million in total one-time funds. This is based on an estimated maximum cost per site of $5,000 times 5,797 sites. The estimated number of sites is derived from the total amount of eligible sites that are not already participating in the Rural Health Support Program (8,297 total eligible sites minus 2,500) The base number of currently eligible sites is taken from *"Report on Health Care Providers Eligible for Support under the Rural Health Care Universal Service Support Program"* FCC document, April 5, 2002.

healthcare institution.[8] As this is also outside of the normal recurring costs associated with the rural health and broadband services programs we feel it appropriate that such costs be covered in the Infrastructure fund.

To guard against a sudden expansion of the program for such non-recurring costs, we suggest that the Commission maintain the overall cap for this program at $100 million. In addition, we agree with the idea of setting caps on individual awards such as the limits mentioned in paragraph 102 of the NPRM.

In conclusion, we believe that the $100 million that will be spent on the Infrastructure program can be much better used for one-time non-recurring costs directly associated with the other two programs. These other areas will provide critically needed support for ongoing services that will improve access to care, reduce costs and improve the quality of healthcare for millions of Americans.

II. Improve the Existing Rural Healthcare Support Program

This program was originally established by the Commission following the enactment of the Telecommunications Act. Section 254(h)(1) of Act limits support for this program to "any public or nonprofit health care provider that serves persons who reside in rural areas." Although this program continues to be operated with a series of complicated requirements and should be revised in several areas, it has proven to be of critical importance for many rural health facilities allowing them to maintain broadband telecommunications links with distant health centers and facilitating the exchange of health data and services on a regular basis for residents of remote areas of the country.

ATA's proposed changes:

1. Eligible Healthcare Providers – It is important to ensure that, to the extent feasible, eligibility for participation in this program include facilities that are also eligible for telehealth reimbursement

[8] "We recognize that in some situations service providers may deploy new facilities to serve eligible health care entities, and may seek to recover all or part of those costs through non-recurring charges when service is initiated. Consistent with policies adopted in the schools and libraries support mechanism, we propose that applicants may not seek upfront support for non-recurring charges of $500,000 or more. If non-recurring charges are more than $500,000, they must be part of a multi-year contract, and must be prorated over a period of at least five years." FCC NPRM, Paragraph 102

under Medicare. This will better align federal assistance among federal programs. Therefore, ATA supports the identification of skilled nursing facilities as eligible sites and consider them to be supported under the original intent of the legislation. These institutions were also recently added as eligible sites for Medicare reimbursement of telehealth services. Similarly, we strongly urge the Commission to clarify that community mental health centers also are eligible facilities. This will assure that the FCC's Rural Health program eligibility criteria will include all Medicare eligible telehealth sites, with the exception of individual physician's offices.

In addition, ATA endorses the FCC's proposed addition of off-site administrative centers, data centers and renal dialysis centers and facilities.

ATA also urges the Commission to add one more category of eligible health service provider: Emergency Medical Service Centers and Emergency Medical Transport. These centers all directly serve and are associated with hospital centers and should be considered within the legislative intent of Section 254(h)(7)(B) of the Act. Many EMS/EMT services are using telehealth applications to enhance communications with emergency physicians. This enables a paramedic to communicate with an emergency physician for an early assessment, well before the patient's arrival at the hospital. Such broadband service is also useful in the emergency care hospital setting to allow specialists to be brought in on serious cases and to allow EMS centers to meet requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA).

Some Emergency Services Centers are operated as for-profit entities. ATA recognizes the FCC's reluctance of providing universal service funds to such entities but urges the Commission to recognize those for-profit Emergency Centers that are located in remote rural areas not served by other providers. This can be constructed in the same way that for-profit health clinics are allowed to receive support from the rural health program in certain instances.

ATA encourages the Commission to seek legislative changes to further expand the definition of eligible health care providers to match eligibility requirements under Medicare to the extent that they are not currently eligible under this program. Specifically, we suggest the following entities also be specifically identified as eligible providers:

- hospice providers;

- elementary, secondary, and post-secondary school health clinics;
- residential facilities for mental health; and
- offices of a physician or practitioner[9]

2. Rural Definition – Like the Commission, over the years ATA has struggled with the development of an appropriate definition of rural. However, we still believe that it is in the best interests of the government and eligible healthcare providers that efforts should be made to have a consistent definition across federal programs. Such a sweeping change may not be possible here but a small step can be taken. We recommend that the Commission look at the definition of rural in use by the Department of Agriculture's Rural Utility Services program and make sure that any provider eligible or the RUS program also be deemed eligible for the FCC's Rural Healthcare Support Program.

3. Application Process – There are two recommendations that will greatly improve the efficiency of the program and allow for greater participation as well as enforcement against fraud and abuse:

   - Yearly Filing Requirements: Each year the recipient of rural health program funds has been forced to re-file and recertify in order to continue receiving benefits. This has caused an unnecessary paperwork burden since, from year-to-year, there are seldom any changes in the circumstances around a recipient's eligibility to receive funds. There appears to be a recent change in this policy by the universal Service Administrative Corporation but we urge the Commission to make sure that USAC has fully implemented an "evergreen" provision, whereby for a period of 3 consecutive years from the initial date of approval, a recipient will only be required to re-file to assure the service is still being used for healthcare (current Form 467).

   - Streamline the Complicated Application Process: The legislation calls for reimbursement equal to the difference "between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State." However, there is no stipulation as to how such reimbursement is calculated. The current application process requiring posting of bids, filing certification forms, etc. has proven to be onerous to some rural health providers and ATA has heard complaints about the process. Indeed, there is evidence that the process has become a barrier to

[9] There are approximately 300,000 physician offices in the United States. How many are located in FCC-defined rural areas are unknown.

participation and is one of the leading reasons why the program has not met initial expectations over the past ten years.

ATA suggests that the FCC explore the development of a new process to offer an appropriate discount that a rural healthcare provider should receive under this program but not requiring local bids, and certification by a rural provider. Specifically, we encourage the Commission to consider the use of flat rate discounts, similar to the approach used in the current internet access program. The rate of discount can be developed through a simple analysis of the average differential, perhaps segmented on a state-by-state or sub-regional level.

- Technical Support: Failing to develop a more simplified application process, we ask the Commission to establish a national technical assistance center to offer staff support with application development for qualified entities. This is not to be confused with the use of "coaches" as used in the current Pilot Program. This would involve a team of experts who are well versed in the Rural Health Program application requirements as well as the operations of typical health providers to provide hands-on assistance with application development.

4. Grandfathering Provision - In March 2005, ATA submitted a Petition for Reconsideration to the FCC[10]. In that petition ATA requested that the FCC grandfather in the program a number of rural health providers that were once eligible to participate in the FCC Rural Health Program but became ineligible for participation because of a change in the guidelines for the program, including a new definition of rural. We requested that those "Sites would be grandfathered for an indefinite period..." In response to ATA's petition, the Commission extended eligibility to those rural health care providers until June 30, 2011.

   Recently, the Nebraska Public Service Commission filed a request to the Commission that the grandfathering provision be made permanent.[11] The Commission is currently seeking comment on this request.[12] ATA is in support of this request for the same reasons stated in our first Petition for

[10] ATA Petition for Reconsideration of the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking (*Second Report and Order*), Docket No. 02-60

[11] Letter from Anne Boyle, Commissioner, Nebraska Public Service Commission, to Federal Communications Commission, WC Docket No. 02-60 (filed Jul. 26, 2010).

[12] Comment Sought On Request To Permanently Grandfather Rural Health Care Providers That Received Funding Commitments Prior To July 1, 2005 So That They Will Remain Eligible For Universal Service Support WC Docket No. 02-60

Reconsideration. One of the leading arguments we made at the time was that *"The loss of existing health care facilities supported by RHCD/USF subsidies for broadband access, that prior to the subsidies were unaffordable, will result in the loss of health care services to populations that have unmet health care needs, that are remote and rural to the location of those services, and are most disparate."*[13]

III. Expand the Proposed Health Broadband Services Program (formerly Internet Access Program)

The current Internet Access Program provides a 25 percent flat discount on monthly Internet access for rural health care providers and a 50 percent discount for health care providers in states that are entirely rural. Unlike the Rural Health Program, this program operates under the broader authorization of Section 254(h)(2) of the Telecommunications Act.

Current utilization of the Internet Access Program is very low. It is estimated that only about $2 million is currently spent per year on this program, assisting less than 1,000 projects nationwide.

Besides a change in the name, the NPRM proposes a change in the current program in two important ways. The monthly discount would be raised to 50 percent of an eligible rural health care provider's recurring monthly costs and eligible services are expanded to include any advanced telecommunications and information services that provide point-to-point broadband connectivity.

We applaud the Commission in making this proposal. It is an important step in the right direction. We offer a number of suggestions to improve and expand this initiative to better meet the needs of healthcare and fulfill the visions outlined in the FCC's National Broadband Plan and the 2010 Patient Protection and Affordable Care Act (healthcare reform). Our proposals also seek to ensure the FCC's Health Broadband Services Program will support and be consistent with other federal programs and initiatives.

ATA's proposed changes:

[13] *ibid.* ATA Petition, Page 9

1. Eligible Healthcare Providers – Like the rural health program, it is important to ensure that, to the extent feasible, eligibility for participation in this program include facilities that are also eligible for telehealth reimbursement under Medicare. This will better align federal assistance among federal programs. ATA supports the expansion of eligibility to the same types of providers mentioned in the above discussion regarding the Rural Health Program.

2. Eligible Provider Location - Unlike the Rural Health Program limitations, this program, authorized under Section 254(h)(2)(A) of the Telecommunications Act (Advanced Services), is not limited to rural locations, nor other pre-determined definitions of eligibility. Federally designated Health Professional Shortage Areas and areas with shortages of medical specialists are not limited to rural locations. Many metropolitan counties have large areas that are rural by any other common measure (Grand Canyon National Park, for example, is considered within a Metropolitan area). Also, many metropolitan counties are small in population – about 500 have less than 75,000 people. Every state has at least one SMSA (Standard Metropolitan Statistical Area); New Jersey, Rhode Island and the District of Columbia are totally in one or more SMSAs. In the U.S., there are 363 SMSAs, encompassing 1092 counties, ranging in population from Carson City, Nevada SMSA with about 55,000 on up. Many metropolitan beneficiaries face major barriers to getting necessary health services. Provider shortages and transportation challenges exist in many SMSAs. Therefore, ATA suggests the program should be available to all health providers regardless of location.

3. Dual Program Eligibility – There have been suggestions that participation in the Health Broadband Services Program should be limited to providers that are not currently participating in the FCC Rural Health Program. After careful review of this issue and discussions with current rural health and Internet grantees ATA believes that many applicants of the rural health program will still need assistance with gaining Internet access. Such Internet access costs can be prohibitive for some health providers. Therefore, we urge the Commission to adopt a provision whereby Internet access support can still be available to Rural Health Program participants.

4. Minimum Broadband Speeds – While we support the concept in the National Broadband Plan for downstream speeds of broadband services, we are very concerned that that high levels of minimum connection speeds are either not available for much of the country or at exorbitantly high rates,

especially in the most rural areas of the country.[14] Such artificially high minimum speeds are considerably above current telemedicine usage in almost all of the existing telemedicine networks except in very limited cases. In addition, there is no reference in the NPRM to a minimum upstream speed. The ability of providers to quickly send video, still images and data, both ways, is critical.

According to prices published by USAC on their web site, the average urban rate for a 1.5 Mbps line (DS1) ranges from $250 to $600 per month depending on then state. Achieving a 10 Mbps minimum connection (the stated minimum for a small clinic) could require about $21,000 to $50,400 on average per year,[15] plus the cost of Internet services. The average rural rate has been stated as approximately 2.5 times the rural rate. Therefore, the total cost for a small clinic could be as much as $150,000 per year to meet the minimum speed under this program[16]. Even with an 85% discount, most small clinics could not afford such costs, nor would it be justified based on current utilization.

Telemedicine networks across the country have been operating successfully at considerably lower thresholds than those specified as minimum speeds. Two of the largest networks in Arizona and Virginia are prime examples. In Arizona, the entire network backbone is operated on a 45 mbps with many sites connecting with a 1.5 mbps line. Since the beginning, the network has provided over one million telemedicine consultations using live video as well as hundreds of thousands of large data packets for imaging. In Virginia, the University of Virginia's network runs with a 10 mbps backbone with sites connecting at 1.5 to 3 mbps speeds. In the future, both networks hope to increase bandwidth but do not foresee the need to meet anyway near the NPRM's minimum speeds anytime soon.

We are concerned that such extreme overbuilding of networks will drain funds away from other eligible applicants, cause substantial delays in the rollout of this program and lead to widespread misuse of universal service healthcare funds for non-healthcare activities.

We call on the FCC to revisit the minimum speeds stated in the broadband plan and set forth minimum speeds that are more in line with current utilization. This can be accomplished with the

[14] The guidelines include: up to 4 Mbps for a solo practitioner, 10 Mbps for small clinics and health care providers with 2 to 4 physicians, 25 Mbps for larger clinics and health care providers with 5 or more physicians, 100 Mbps for hospitals and 1,000 Mbps for large medical centers.
[15] This uses using a very rough approximation of DS1*7*12. Typical prices for multiple T1 lines are slightly cheaper.
[16] The costs would probably be somewhat lower for most areas but the example demonstrates the range of costs and for the most remote areas the costs might be even higher.

use of an advisory panel composed of current providers of telemedicine services. These broadband speeds should be reviewed annually to assess recent changes in available technology as well as revisions in widely accepted practices among health providers.

5. Eligible Communications Vendors and Eligible Transmission Technologies – As stated before, this is a critically important program supporting the nation's healthcare reform goals. Therefore, it is imperative that the program's administrative procedures encourage competition from all telecommunications providers and full flexibility to meet the evolving nature of healthcare delivery.

   The communications vendor selected should be the lowest bidder that meets the requirements set forth by the healthcare provider without any restriction set by the FCC on whether that entity is commercial for-profit or non-commercial non-profit entity. There are numerous national backbone networks available and all are interoperable. This allows the healthcare provider to choose among the most cost-effective and most reliable service providers.

   Healthcare providers should be able to choose whether the telecommunications service is provided via wireline or mobile service or a combination of both. As healthcare becomes more mobile and wireless telehealth becomes main-stream, the Commission needs to remain neutral to the method used to carry signals.

6. Level of Financial Support – The notice proposes that the amount of support provided for these services be increased from 25% to 50% of the monthly recurring costs. ATA and many others have previously submitted comments to the Commission requesting the monthly discount to be at least at 75%. In the NPRM, the Commission stated *"on average, health care providers that applied for the urban/rural cost difference for eligible telecommunications services under the existing telecommunications program received funding commitments for a 60 percent discount on their cost of service; a significant number of those funding commitments are for T-1 lines."*

   Based on this average, we suggest that a 60% discount should be available as the base for any eligible healthcare facility.

Of particular concern is connecting health providers that serve areas of greatest need. Responding to such national concerns deserves a greater incentive. Therefore, we also suggest that eligible providers located in rural areas defined by the FCC for the rural health program and those serving federally designated Health Professional Shortage Areas (HPSAs) in urban areas, should receive an 85% discount.

7. Non-Recurring Charges – ATA supports the provisions of installation charges for broadband connectivity and limitations related to infrastructure and construction charges. We also support the inclusion of a portion of the build-out costs within the monthly operating fees for broadband services but only in areas where no other such broadband capabilities are otherwise available by any other telecommunications carrier. As stated above, we suggest that these costs be covered within the proposed Health Infrastructure Program.

   We also urge the Commission to enter into discussions with the leaders of the Department of Commerce's National Telecommunications Information Administration and the Department of Agriculture's Telecommunications Assistance programs to explore ways their programs may be leveraged to support such build-outs, instead of using universal service funds.

8. Fund Ceilings - Based upon the projected utilization of this program there may need to be a maximum ceiling placed on the individual awards in order not to exceed the $400 million ceiling. If this is needed, this should be a uniform amount applied to each applicant.

IV. Data Gathering and Performance Measures

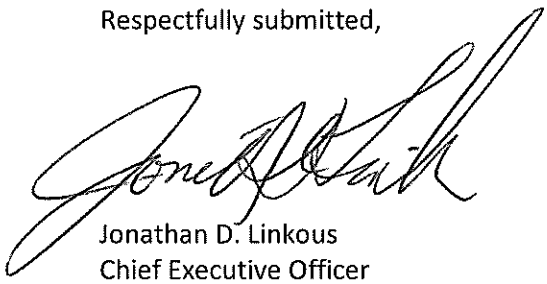
The Notice makes an important point about the need to ensure the proposed initiatives "are useful to medical facilities, health care providers, and patients." We agree with this premise. However, it must also be acknowledged that the FCC healthcare programs have become notorious for the enormous amount of regulatory and paperwork burden required of applicants and recipients of funds. Therefore ATA offers the following recommendations:

1. Meaningful Use - Do not require eligible recipients to use the meaningful use criteria to determine the success of the program. Those criteria are intended to measure the use of electronic records, not the use of telecommunications services to provide health services. Further, the documentation related to such use for telemedicine applications would involve a great deal burden on providers already faced with enormous documentation requirements. More pertinent to the FCC is to facilitate the telecommunications needs for health information exchange. Accordingly, the Commission may be interested in asking applicants and programs to describe briefly the involvement of participants in state and national health information exchange.

2. Annual Report - An annual report should be required that documents the level and number of connections made with other sites with the telecommunications services and the number of healthcare services delivered. The Commission should require recipients to provide annual reports to attest to the use of the services for healthcare in order to receive ongoing reimbursement for these expenses.

Finally, ATA applauds the Commission's efforts to support the expanded delivery of quality, affordable healthcare services through telecommunications. We believe the proposed new initiatives of the Commission, as amended by these comments, will help to improve the lives of millions of Americans throughout the nation.

Respectfully submitted,



Jonathan D. Linkous
Chief Executive Officer
American Telemedicine Association
1100 Connecticut Avenue, NW
Suite 540
Washington, DC 20036

ATTACHMENT 1

American Telemedicine Association
2010-2011 Board of Directors

Executive Committee

President
Dale Alverson, MD
Medical Director, Center for Telehealth
University of New Mexico Health Sciences

President Elect
Bernard A. Harris, Jr., MD, MBA, FACP
President and CEO
Vesalius Ventures and Harris Foundation

Vice President
A. Stewart Ferguson, PhD
Director of Telehealth
Alaska Native Tribal Health Consortium

Secretary-Treasurer
Seong Ki Mun, PhD
Director
Institute for Advanced Study, Virginia Tech-NCR

Immediate Past President
Karen S. Rheuban, MD
Medical Director, Office of Telemedicine
Professor of Pediatrics, Senior Associate Dean for CME and External Affairs
University of Virginia

Board Members

Ed Brown, MD
Executive Director
Ontario Telemedicine Network

Mark Carroll, MD
Director of Telemedicine
Indian Health Service

S. Ward Casscells, MD
University of Texas Health Science Center
Immediate Past Assistant Secretary of Defense for Health Affairs

Molly J. Coye, MD, MPH
Chief Executive Officer
Health Technology Center

Mr. Sunil Hazaray
President & CEO
Bayer HealthCare

John P. Howe, III, MD
President and CEO
Project HOPE

Donald Jones, JD
Vice President, Business Development Health and Life Sciences
QUALCOMM

James A. L. Mathers, Jr., MD, FCCP
Pulmonary Associates of Richmond
Immediate Past Chair
American College of Chest Physicians

Ronald C. Merrell, MD, FACS
Virginia Commonwealth University
Co-Editor In Chief Journal of Telemedicine and eHealth

Jay H. Shore, MD, MPH
Associate Professor
University of Colorado at Denver American Indian and Alaska Native Programs

Lord Roger Swinfen
Founder & Trustee
The Swinfen Charitable Trust

Reed Tuckson, MD
Executive Vice President, Chief of Medical Affairs
UnitedHealth Group

Yulun Wang, PhD
Chairman & CEO
InTouch Health

Peter Yellowlees, MD, MBBS
Professor of Clinical Psychiatry
Department of Psychiatry and Behavioral Sciences
UC Davis Health System